NEVADA HEALTH AUTHORITY
NevadaMedicaid.nv.gov

July 22, 2026

Nevada Medicaid Web Announcement 3970

Attention Provider Type 63 (Psychiatric Residential Treatment Facility (PRTF)):

Rate Reform Implemented for Private PRTFs

Update to Web Announcement 3640: State Plan Amendment (SPA) #25-0002 has been approved by the Centers for Medicare & Medicaid Services (CMS). This SPA amends the reimbursement rates for private facilities under provider type (PT) 63 (Psychiatric Residential Treatment Facility (PRTF)). Effective January 1, 2025, all private PRTFs will receive a flat rate of $800 for revenue codes 100 and 183.

In addition to the new flat rate, a new special rate of $150 can be added to the flat rate for a maximum of $950. This special rate is available only for children less than 10 years old or children with complex needs. Prior authorization (PA) is required to receive the special rate and must be submitted using new revenue code 120 effective August 1, 2026.

Beginning August 1, 2026, use Psychiatric Residential Treatment Facility Prior Authorization (form FA-15) to submit PA. This form will be updated to include the complex case definition criteria and is available on the Nevada Medicaid website on the Forms page.

Claims submitted by PT 63 with dates of service on or after January 1, 2025, that did not pay the new flat rate will be reprocessed automatically. Claims with dates of service on or after January 1, 2025, for children less than 10 years old who qualify for the added $150 will also be reprocessed automatically. Results of the reprocessed claims will appear on future remittance advice.

Nevada Medicaid is making a one-time exception to reimburse providers at the reimbursement rates listed on the fee schedules whether the provider is billing usual and customary charges or not. Providers are reminded that billing their usual and customary charges is **required** by the Medicaid Services Manual Chapter 100, Section 105. This exception is granted due to the high priority of children's behavioral health services for Nevada Medicaid, and is not likely to be granted with any subsequent rate increases.

When claims are reprocessed, please be aware that all system and clinical claim editor edits are applicable. As a result, there may be no additional payment, and other claim denials may be received. Providers have the right to appeal denied claims, including those denied upon reprocessing. Please refer to Medicaid Services Manual Chapter 100 and the Billing Manual for information concerning the claim appeal process and time frames.

Effective January 1, 2026, Managed Care Organizations (MCOs) have up to 60-days after receiving updated rate files to implement rate changes on a go-forward basis, unless otherwise specified by the State. MCOs must implement rates for FQHCs, CAHs, RHCs, and other cost-report based rates effective when the State prescribes them, including retroactively, as applicable. This provision does not limit the MCOs' ability to apply cost-containment or avoidance activities that reduce costs or prevent fraud, waste, or abuse.